Equality, Inclusion and the Health of Canadians

Submission to the Commission on the Future of Health Care in Canada

November 15, 2001

Submitted by the Canadian Council on Social Development
309 Cooper St., 5th Floor
Ottawa, ON K2P 0G5
E-mail: council@ccsd.ca
Internet: www.ccsd.ca

Executive Summary

Modernizing the public health care system to meet the challenges of the 21st century must proceed hand in hand with efforts to reduce poverty and income inequality in Canada. The CCSD proposes the following recommendations "to ensure the sustainability over the long term of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investment in prevention and health maintenance and those directed to care and treatment." (www.healthcarecommission.ca)

1. Preserving and Protecting Medicare

We believe that health is a fundamental right of each citizen. Achieving health for all Canadians requires a system of public health that is organized on the basis of public administration, public insurance and the delivery of services on a not-for-profit basis. This is not to say that change is not necessary; change in the face of new realities – fiscal, demographic and technological – is critical to ensuring the integrity of the public system. To that end, we and many other organizations endorse the need to preserve and protect Medicare by:

- Adopting a renewed vision for health care, based on the principles of the Canada Health Act.
- Ensuring an integrated continuum of community-based and institutional services and supports.
- Strengthening the development and delivery of public health, including environmental regulation and protection.
- Acting on primary care reform.
- Supporting needed health infrastructure.
- Facilitating public participation in the planning, delivery, monitoring and evaluation of the health care system.
- Providing stable funding.
- Protecting our health system in international trade agreements.

2. Creating a More Equal and Inclusive Society

Confining reform to the formal health care system alone, however, will not necessarily result in improved health among all Canadians. We believe there is a vital need to locate the health care reform debate in the larger socio-economic context. A growing body of international evidence – including our own work at the CCSD – highlights the importance of broad social and economic determinants of health; specifically, income inequality is highly correlated with poorer health outcomes. Reducing income inequality must be a central component of any plan to improve the health of Canadians, especially for those most vulnerable to poverty and diminished life chances.

The CCSD recommends action on three interrelated fronts.

Closing the Employment Gap

- Increasing the minimum wage.
- Pro-rating of benefits for part-time workers.
- Redistributing working time through limits on overtime, job sharing and enhanced leave provisions.
- Improving employment and pay equity legislation.
- Facilitating collective bargaining, notably in the private sector.
- Improving employment provisions for temporary or contract workers.
- Improving health and safety regulations.

Closing the Income Gap

- Increasing social assistance incomes and services through increased federal transfers to the provinces, combined with some shared development of national standards.
- Establishing a federal program, possibly modelled on CCTB, to provide income supplements directly to working-poor and modest-income households.
- Increasing existing federal tax credits (the CCTB and GST credits), and creating a new refundable tax credit for persons with disabilities.
- Extending the coverage of the EI system by revisiting restrictive eligibility requirements that have radically curtailed program coverage.
- Considering an Earned Income Tax Credit to supplement the incomes of working-age single Canadians who work, but still fall below the poverty line.

Closing the Common Goods Gap

The third strategy we would like to highlight is the critical need for enhanced public supports and services, especially for groups vulnerable to poor health and life outcomes. The availability of services touches the lives of Canadians in many ways, and all work to enhance and protect our collective quality of life and well-being. Public service provision through partnerships with the voluntary sector also represent a better way to deliver human services and to ensure public accountability. Strengthening the public network of non-profit services and supports – closing the common goods gap – is vital to securing the well-being of Canadians.

I. Introduction

The Canadian Council on Social Development (CCSD) is an independent, national, non-profit organization led by a volunteer board of directors from across Canada. Primarily a research and advocacy organization, the CCSD focuses on issues of social and economic security. The Council's close to 1,000 members include professionals in human service organizations and businesses, volunteers, union members, academics, and provincial government departments who share a commitment to improving the lives of Canadians.

We believe in:

- The right to economic security and an adequate standard of living for all;
- Universal access to basic social and health programs;
- Public participation in improving social conditions;
- A fair, compassionate and inclusive society, with equal rights for all.

We welcome this opportunity to address the Commission on the Future of Health Care in Canada. Since our founding in 1920, the CCSD has been engaged in the key policy debates of the day. In the early years and in response to alarmingly high rates of infant mortality, the Council championed the need for universal immunization programs. Since then, we've helped establish some of Canada's most progressive social reforms, including Medicare, the Canada Assistance Plan, social and cooperative housing, and tax credits for the working poor. More recently, we have played an important role in charting a new course for Canada's social safety net, one that is organized around the importance of children and families.

The CCSD's research activities provide the basis for our policy and advocacy efforts. We have developed expertise across a broad range of areas that broadly relate to social and economic security, including poverty and income inequality, labour market dynamics and social well-being. Our most recent work centres on the concept of *social inclusion*, which we believe provides a useful framework to advance progressive public policy. First, it draws attention to the fact that persons can be excluded from society for many reasons, including disability, illiteracy and racial discrimination. Second, this concept speaks to the multiple dimensions of well-being or deprivation beyond income, such as active participation in society, recognition by others, and the ability to develop one's individual talents and capacities to the full. Third, social inclusion makes it clearer that the goal is not just to abolish poverty, but also to live in a society where there are limited gaps and distances between people with respect to income, and also with respect to broader opportunities and life-chances. Such a framework, we believe, has much to offer the health care reform debate.

It goes without saying that the problems besetting the health care system and the potential solutions are complex. The excellent work of previous commissions such as the National Forum on Health, the Fyke Commission in Saskatchewan, and the Clair Commission in Quebec have documented the challenges in promoting the health of Canadians and they have provided many worthy recommendations. Similarly, research institutes around the country such as the Centre for Health Services and Policy Research at UBC and the Canadian Centre for Policy Alternatives, as

well as health sector groups such as the Canadian Public Health Association are working to promote reform of the public health care system. The key theme running throughout this varied body of work is the importance of preserving and protecting Medicare.

The CCSD strongly believes that the public health care system is the most efficient and effective way to fund and deliver health care services. We strongly endorse a publicly funded, single payer, non-profit health care system. Indeed, we believe that it is critical to expand the public health care net to create a more comprehensive spectrum of services. The claims of private market proponents are demonstrably false: greater privatization will *not* result in greater efficiency at reduced cost. And it certainly won't result in improved health among all Canadians. Health care reform must proceed within the framework of the public system.

That said, we believe that there is a vital need to locate the health care reform debate in the larger socio-economic context. A growing body of international evidence – including our own work at the CCSD – highlights the importance of broad social and economic determinants of health. Specifically, both poverty and income inequality are highly correlated with poorer health outcomes. Modernizing the public health care system to meet the challenges of the 21st century is important, but specific reforms must proceed hand in hand with efforts to foster social and economic inclusion in Canada. Reducing exclusion must be a central component of any plan to improve the health of Canadians, especially for those most vulnerable to poverty and diminished life chances.

In the next two sections, we set out arguments that establish the links between economic inequality and health outcomes. In Section IV, we review and refute demands for greater privatization of health care. Section V presents the case for reforming the public health care system and our recommendations to tackle poverty and income inequality – the most serious threats to the health and well-being of Canadians.

II. Growing Income Inequality

Governments across Canada are struggling to modify the key pillars of the post-war welfare state in an attempt to accommodate new realities. The large-scale entry of women into the paid labour force and the ageing of the population are but two examples of forces that have changed our society over the last 30 years. All of this is taking place against a backdrop of profound economic change, which has been accompanied by growing economic inequality.

While family incomes finally began to recover from the effects of the 1990-91 recession by the end of the decade, the gap between "the haves" and "the have-nots" grew wider (See Ross, Scott and Smith, 2000; Jackson, Scott and Schetagne, 2001). Higher levels of employment, particularly among full-time workers, coupled with a growth in wages have led to higher earnings. In 1999, average market income reached $56,998 among families and $22,038 among unattached individuals. Improvements in the labour market were also largely responsible for a decline in the rate of poverty. Using the pre-tax low income cut-offs, the poverty rate among all Canadians fell from 16.8% in 1998 to 16.2% in 1999, representing an estimated 4.9 million people. Looking at the

poverty rate among households, rates have dropped among families (from 13.0% to 12.2%), and among unattached individuals (from 39.2% to 38.9%) over the same time period.

These overall gains mask a very disquieting picture, however. While fewer people were living in low-income households in 1999, the poverty rates remain above those recorded in 1989. Moreover, the poverty gap – that is, the gap between the poverty line and the average income of poor families or persons below the line – has grown over the decade; the average gap was $8,089 for families and $6,352 for unattached individuals. The economic standing of some families improved, notably for families with children, but most have yet to regain the ground they lost over the decade.

This gap in incomes among Canadians has been growing throughout the 1990s, and notably so since 1994. Market incomes in particular have become more polarized. In 1989, the top 20% of families received 41.9% of market income; by 1999, their share was 44.4%. In contrast, the income shares of families in the lowest, second and middle quintiles fell over this period: by 0.7, 1.5 and 0.9 percentage points, respectively. Stated another way, families in the top quintile in 1989 received $11.00 in market income for every dollar earned by families in the lowest quintile. By 1999, this gap had widened to $12.70 for every dollar.

Rate of Poverty in Canada
Pre- and Post-tax LICOs, 1989, 1998, 1999

Pre-tax LICO	1989	1998	1999
All persons	14.0	16.8	16.2
<18 yrs	15.2	19.0	18.5
18-64 yrs	9.0	15.5	15.0
65+ yrs	18.9	19.6	17.7
Post-tax LICO			
All persons	10.2	12.1	11.8
<18 yrs	11.8	13.9	13.7
18-64 yrs	7.0	12.1	11.8
65+ yrs	9.1	8.7	8.2

Source: Statistics Canada, Income in Canada 1999. Catalogue no. 75-202-XIE;

The impact of transfers and taxes was important in offsetting the widening gap in market incomes during the first half of the 1990s. After 1994, however, the gap in after-tax incomes started to grow, falling only between 1998 and 1999. The income share of families in the top quintile grew by 1.3 percentage points between 1989 and 1999, while families in the lowest quintile saw their share fall by 0.2 points.

The positive income gains of 1999 are welcome. It would appear that the economy lifted many more families in 1999 compared to 1998. But it is also evident that poverty levels are unlikely to

return to their pre-recessionary levels. And data on the number of people experiencing poverty even during boom periods – an estimated one in four Canadians during the period from 1993 to 1998 – provides an important cautionary note. Economic inequality continues to pose a significant threat to the well-being of many, many Canadians.

III. Inequality and Population Health

Income is not destiny, but the link from family household income to poorer social and health outcomes is well-documented. The relationship between socio-economic status and health outcomes is one of the most persistent themes in the epidemiological literature. The strong and growing evidence that higher social and economic status is associated with better health has led most researchers to conclude that these factors are fundamentally important determinants of health. Therefore, growing income inequality poses a significant threat to the health of Canadians today.

The connection between income and individual and collective well-being has long been recognized. In Canada, the first major analysis of social status and health was completed in 1938 (Marsh et al., 1938). Surveys focusing on the health experiences of employed and unemployed workers and their families found that various health problems were more prevalent among the unemployed. The authors concluded that, while the situation could be improved by the availability of medical services, unless the prior social conditions giving rise to these inequalities were improved, social status differences in health would remain.

More recently, the Lalonde Report in 1974 – arguably the most important health policy document of the post-war period – developed the idea that health policy was broader than simply health care. It argued that healthier lifestyles, better nutrition and healthy communities had a greater role in health than the advancement of medicine (Lalonde, 1974). The health promotion framework first advanced in the Lalonde Report was subsequently expanded in 1986 with the publication of *Achieving Health for All: A Framework for Health Promotion.* The Epp Report broadened the understanding of health determinants beyond individual lifestyles to include environmental determinants such as income. Reducing income inequalities among Canadians was explicitly identified as a major health challenge (Epp, 1986: 4).

In the 1990s, these ideas have been developed further under the rubric of population health. Literature on population health advanced by organizations such as the Canadian Institute of Advanced Research has explored the importance of income and its distribution as a key determinant of population health, asking the question: "Why are some Canadians healthy and others not?" (Evans, Barer and Marmor, 1994). This work has informed recent federal and provincial health policy. The Federal-Provincial-Territorial Committee on Population Health has published two reports that highlight the sometimes gross inequities in health evident in Canada (FPT Advisory Committee on Population Health, 1996 and 1999). These reports and others make the point that "it is not [just] the amount of wealth but its relative distribution which is the key factor that determines health status." (Hamilton and Bhatti, 1996)

There is a growing consensus in Canada – and worldwide – that economic inequality impacts health (Kawackhi, Wilkinson and Kennedy, 1999; Marmot and Wilkinson, 1999; Wilkinson and Marmot, 1998). As the World Health Organization states:

> Medical care can prolong survival after some serious diseases, but the social and economic conditions that affect whether people become ill are more important for health gains in the population as a whole. Poor conditions lead to poorer health (Wilkinson and Marmot, 1998: 7).

Succinctly stated, more equitable and inclusive societies tend to be healthier societies. Yet the debate about the social determinants of health continues to be largely confined to academe and selected public health fora. We need to bring this knowledge to the health care debate through venues such the Commission on the Future of Health Care to inform proposals for change. **Reducing income inequality must be a central component of any plan to reform Canada's health care system.**

Income inequality affects health through many pathways

Absolute Material Deprivation (Poverty)	engaged in dangerous / stressful employment
	poor nutrition / substandard housing
	living in unsafe, polluted neighbourhoods
	adoption of unhealthy behaviours, e.g., smoking
	lack of access to benefits / services
Relative Material Deprivation (Inequality)	diminished life expectations, lack of hope
	knowledge of marginality
	lack of personal control, uncertainty associated with social status
	decreased social cohesion / social disintegration

1. Poverty and Health

The links between low income and health are clear, but our understanding of how these links work is still evolving. There are two main arguments. The first looks at the impact of low income or poverty on health status. Poverty's effects on health are direct, related to *absolute* material deprivation, and indirect through psychosocial reactions to *relative* deprivation. Being poor means not having a nutritious diet, not having enough money at the end of the month to pay the gas bill, not having neighbourhood parks nearby, not having access to a car or ready access to public transit, not being able to visit a dentist – all of which detrimentally affect health and well-being. Being poor also means in the words of children from North Bay, "feeling ashamed when my dad can't get a job," "not getting to go to birthday parties," "not being able to have friends sleep over," "pretending you forgot your lunch," "hiding your feet so the teacher won't get cross when you don't have boots," "not getting a hot dog on hot dog day," or "being teased for the way you are dressed" (CCSD, 2000).

Poverty has real consequences for health. A 1996 study by the Canadian Council on Social Development report, *Child Poverty: What Are the Consequences?* shows that poor children are much more likely than children from higher-income families to experience a host of negative outcomes, including higher rates of disability, mental health problems, lower levels of educational attainment, and higher rates of injury. Poor children are also much more likely to engage in risky health behaviours such as smoking and drug or alcohol consumption (Ross, Scott and Kelly, 1996). Researchers also stress the psychosocial impact of poverty on individuals, reflected in feelings of helplessness, lack of control and insecurity (Taylor, Repetti and Seeman, 1997, cited in Raphael, 1999).

This is not only a question of low family income – that is, the lack of adequate housing or a healthy diet. Income works through many pathways to shape the well-being of individuals, families and communities. Research based on the NLSCY investigating the relative importance of the child's community environment has found that children's involvement in activities such as cultural activities or sports – which is largely influenced by household income – can provide protection from emotional and social problems, which in turn has implications for health. For example, children who participated in the arts were 31% less likely than non-participants to have one or more problems, even after taking into account a contribution of other factors. The rate of "almost never" participating among the very poor was more than twice that of well-off children – 59.6% versus 27.3% (ARB, 1998). Community factors such as the availability of good parks, playgrounds and play spaces in the neighbourhood were strongly associated with increased participation. For example, neighbourhoods with these characteristics had sports participation rates that were 10% higher than neighbourhoods without these amenities.

The emphasis on community factors highlights the impact of broader social and political structures on poverty and poor health as well. Societies marked by high levels of poverty invariably have weak social safety nets. There are comparatively few social benefits or services that address the consequences of market poverty. Cutbacks to services further skew the distribution of resources in favour of the affluent, perpetuating the cycle of poverty and poor health (Bartley, Blane and Montgomery, 1997, cited in Raphael, 1997). Lack of access to services like health care constitutes a real threat to the health of poor and modest-income Canadians (Raphael, 1999).

2. Income Inequality and Health

A number of researchers in Canada and elsewhere have also shown that *income inequality* – the actual distance between citizens – is equally if not more important than the level of absolute income. Differences in health status exist among people across the socio-economic gradient, not just between the rich and the poor (Marmot and Wilkinson, 1999). The larger the gap between rich and poor – that is, the more unequal the distribution of income – the greater the gap in health outcomes. Living in substandard housing, working at dangerous work sites or playing in high pollution neighbourhoods – all hallmarks of living in poverty – has an impact health. Life at the bottom of the income ladder, however, also has pronounced psychological effects. Researchers point to the impact of relative deprivation, the stress associated with knowing that one is on the outside looking in (Kawachi and Kennedy, 1997).

Perhaps the most famous study illustrating the very real consequences of income inequality is the Whitehall study of British civil servants. Begun in 1967, the study reveals a steep inverse association between social class (assessed by grade of employment) and mortality from a wide range of diseases (Reid, 1971). After 10 years of follow-up, those in the highest grades of employment had about one-third the mortality rate of those in the lowest employment grades. This difference in mortality was only partly explained by differences in age, smoking, systolic blood pressure, height, plasma cholesterol and blood glucose. Based on the limited data available, there were also substantial socio-economic differences in morbidity (Marmot, 1993). A second longitudinal study, conducted between 1985 and 1988, included women and confirmed the results of the first study.

In Canada, Russell Wilkins, Nancy Ross and Michael Wolfson at Statistics Canada have pursued important work advancing our understanding of income inequality and health status. To illustrate, Russell Wilkins, in his work linking income level and mortality from injury and disease, found that about 50% of men living in the poorest neighbourhoods in 1995 will live to age 75, while almost 70% of men from the richest neighbourhoods will reach that age. This study and others confirms that the relationship between health and neighbourhood income is a gradient such that health increases at each step of the hierarchy in income, education or social status (Wilkins, 1995).

Nancy Ross and Michael Wolfson have linked mortality to income inequality at the state and provincial level, and at the municipal level. Annual mortality among working-age adults ranges from a high of 675 per 100,000 in the most unequal American states, to 400 or less per 100,000 in the most equal American states and Canadian provinces (Ross et al., 2000). American research also confirms the link between income inequality and poor health outcomes. The more "unequal" states have higher death rates including higher infant mortality, death from heart disease, death from cancer and death by homicide (Kennedy et al., 1997). These studies show that it is not the absolute level of wealth in a society that determines health, but how evenly it is distributed.

3. Income Inequality and Public Health Care

Understandably, much of the research in this area tends to focus on the links between income inequality and individual-level biomedical and behavioural risk factors such as smoking or obesity (Raphael, 2001a). In part, this is a function of the limitations of existing data sets. Yet the importance of structural mechanisms – such as government income security policy or unemployment – is becoming increasingly clear as new research highlights the relatively small role that individual biomedical and lifestyle risk factors play in accounting for variance in the incidence of many illnesses (Lantz et al., 1998; Marmot and Mustard, 1994; Raphael, 2001b; Wood et al., 1999, cited in Raphael, 2001a).

The character of the health care system itself has emerged as an important factor in explaining differences in population health among high-equality and low-equality countries (Ross, 2000). Access to health care is clearly an important factor. Consider the example of Canada and the United States. In Canada, there is little difference by income group in the prevalence of visits to general practitioners, whereas in the United States, there is a pronounced socio-economic gradient: those with higher levels of income visit family doctors more frequently. Not surprisingly, access to health care specialists follows a similar pattern. The obverse is true when we look at visits to emergency

departments. The use of hospital emergency departments tends to be higher among the poor in both countries, but the socio-economic gradient is much more pronounced in the United States (Wolfson, 2000).

On the most basic of measures, Canadians can, on average, expect to live for 79 years, 72 of which will be lived free of disability. In the United States, both life expectancy and disability-adjusted life expectancy at birth are two years less than in Canada. As we have argued, the distribution of income is certainly one of the reasons that Canadians can expect to live longer and more healthy lives than Americans. But it is also true that Canada's universal health care system plays an important role. The presence of public systems of support also reflects higher levels of social cohesion or, perhaps more accurately, greater citizen commitment to society as a whole.

4. Health Policy and Income Inequality

What does all of this mean for health policy? How can we improve the health status of all Canadians, especially those who are socially and economically excluded?

Typically, the intended impacts of policies aimed at reducing poverty and income inequality are economic and social outcomes. Health outcomes are not usually the target of poverty reduction. Certainly, proponents of the population health perspective recognize that policy interventions designed to influence the social and economic conditions of people's lives can and do have direct and indirect consequences for health. And conversely, public policies intended to improve population health can confer differential benefits, intentionally or otherwise, on the rich and the poor (Legowski and McKay, 2000). Yet there has been little movement, despite growing evidence, towards adopting a broader approach to health care reform, an approach that would encompass specific strategies to address poverty and inequality.

If the ultimate goal of health care reform is to enhance the health of Canadians – and one presumes that it is – then the way forward must include related strategies that promote the health of Canadians while providing a spectrum of comprehensive supports to address specific health needs as they arise. The arbitrary division between health care and social and economic policy constitutes a substantial barrier to progressive reform.

IV. The False Promise of the Market

Spurred in no small part by government efforts to contain social expenditures – blamed for fiscal deficits of the 1980s and early 1990s – governments are embracing the market as both a model of reform and a source of individual economic security. Private markets are being held up as the model of reform. The clarion call of the market is certainly heard in the health care debate raging in Canada at the present time.

Rachlis, Evans, Lewis and Barer in a paper for the Tommy Douglas Research Institute make the important point that the opponents of Medicare are exaggerating the weaknesses of the public system to advance their own corporate agendas (Rachlis et al., 2001). Succinctly stated, hysteria about the "crisis" in the health care system is overblown, exploitative and baldly self-interested.

Claims that we can no longer afford Medicare, that the principles of the Canada Health Act are no longer relevant, that private, for-profit delivery will lead to a more accessible, less costly system are demonstrably false. While the challenges facing Medicare are very real and complex, the authors argue – and the CCSD concurs – that the answers lie in reforming the current public non-profit model.

Debunking the myths about Medicare will be an important part of the Commission's mandate in promoting informed debate on the "long-term sustainability of a universally accessible, publicly funded health system." Even today, as the federal government prepares to release a budget in December, some Premiers are threatening to pursue greater private sector funding and service delivery to contain the "exploding" costs of Medicare. The provinces argue that without significant new funding from the federal government, there will be little room for other spending priorities such as education, social services or infrastructure.

Health care costs are, in fact, not "out of control." Expenditures on health have certainly risen since 1997 – up $20 billion according to new data from the Canadian Institute for Health Information. However, these increases follow a period of cuts, in the order of 2% a year between 1992 and 1997. In constant dollars per capita terms, the actual and projected increases in public funding for the 1997 to 2001 period are offsetting the significant cuts earlier in the decade. This has been done in the context of an ageing population.

Even if there was an upward trend in total public sector health care costs over time – which is far from clear – the key issue would be whether future expenditures were efficient in terms of meeting our collective health goals. From the perspective of Canadians, any savings would be illusory if the costs were simply shifted from the public to the private sphere, from taxes to household budgets, in order to cap taxes. Privatization of costs does not reduce those costs as a share of national income. It simply redistributes the costs – and in the process, excludes those who cannot afford to pay – and diverts resources to those who can pay. Evidence from the United States suggests that privatization, in fact, increases aggregate costs.

It is useful to note that in comparison with other OECD countries, Canadian public health sector spending accounted for 69.6% of total health care expenditures in 1998, compared to an average of 73.6% for all OECD countries. Canada in fact ranks among the lowest in terms of public sector funding. By comparison, Canada has one of the highest levels of privately funded health services already – roughly 30%. It is almost twice the British rate of 16%, a country that has been held up as a model of private sector reform. (This is largely due to the fact that the British heath system encompasses a broader continuum of care within their publicly funded system.)

And like public sector funding over the last four years, private sector expenditures are growing as well. Over the past decade, private sector health expenditures in constant dollars per capita grew by an average of 2.5% annually, compared to average increases of 1.0% in the public sector. Rising drug costs are certainly one of the main reasons behind the escalation of private and public health care costs. Facilitated by stringent and lengthy patent protections, the high cost of drugs is a very significant barrier to health care access for individuals and families who do not have private sector health insurance or coverage through their places of work.

The growth of private health care costs in recent years has had a disproportionate impact on low-income families. The proportion of their limited budgets directed to health has grown in line with privatization, but at a faster than average rate. The consequences of the market provision of health for those on low incomes can be seen in their lack of access to areas that now lie outside of the public system. For example, the City of Toronto Public Health Department reports very high rates of untreated dental disease among children living in low income, with significant impacts on their participation at school (Toronto Public Health, 2001). Research by the CCSD for our annual report on *The Progress of Canada's Children* has conclusively shown that low income – in the absence of public provision of services – results in a lack of access on the part of many children to key sources of inclusion and well-being. Examples include high-quality early childhood education, decent housing, and developmental recreation programs. The market promises freedom and the ability to choose, but this is an entirely illusory freedom for those who lack the resources to exercise meaningful choices.

We present these data not to suggest that there is a right balance between public and private funding, but to throw light on the debate about greater private funding (such as user fees or health premiums) as a way to solve problems plaguing the Canadian health care system. The discourse of crisis – by those who support and those who threaten Medicare – only serves to undermine the public universal system and make it almost impossible for citizens to get a clear sense of the challenges facing the health care system and the potential solutions that do exist.

Similarly, arguments in favour of greater private sector delivery – two-tiered health care – feed on the language of crisis to create greater room for their for-profit activities. Such arguments completely ignore the decades of evidence that for-profit health care delivery is significantly more expensive, less efficient, less accountable, often of poorer quality, and much less accessible, especially to the most vulnerable members of society (Taft and Steward, 2000, cited in Browne, 2000: 5). Considerable resources are siphoned off into policing, because fraud and corruption are more prevalent in for-profit systems (Armstrong, Armstrong and Fuller, 2000).

Not only is for-profit delivery a poor model for care, introducing competition also has the effect of driving quality down and costs up, even among non-profits. In a study for the Canadian Centre for Policy Alternatives, Paul Browne examined the impact of managed competition on home care in Ontario. He concluded that managed competition has resulted in reduced innovation, co-operation among agencies, and continuity of care. Nurses are pressured to visit increasing numbers of patients each day, substantially reducing the quality of care. Moreover, competition from private, for-profit agencies has led some non-profit providers to try to reduce their wage costs in order to compete, thus effectively driving many nurses out of home care altogether (Browne, 2000). "When non-profit and for-profit firms operate in the same environment, producing the same services and competing for the same customers, they will tend to produce similar quality goods and services" (Woolley, 2001: 26). The considerable advantages that non-profits offer – higher quality service, better working conditions for employees, higher levels of client/employee satisfaction – are lost in a competitive context (Rose-Ackerman, 1996, cited in Woolley, 2001).

The real losers from privatization are the poor. The poor are, in effect, excluded from good health, denied access to the most basic of services and supports, and forced to rely on the unpaid

labour of family, friends and neighbours. One wonders what the possible appeal of the American health care system can be, a system described by the former editor of the *New England Journal of Medicine*, as "the most expensive and most inadequate system in the developed world (cited in Rachlis et al., 2001: v).

Tommy Douglas said in 1961:

> When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barriers between those giving the service and those receiving it. The second phase would be to recognize and revamp the whole delivery system – and of course that's the big item. That's the big thing we haven't done.

That's the task before Canadians now. There is a compelling need to address growing tensions in our health care system – reflected in part by persistent inequities in health among the rich and poor in Canada. The solution lies, however, not in raising greater barriers to care through privatization, but rather in creating a stronger, more comprehensive, publicly funded and administered system of community-based care in conjunction with introducing specific strategies to reduce economic inequality – that is, by addressing the health and well-being of individuals, families and communities.

V. A Prescription for Reform

A new balance is necessary within the established health care system – shifting money from treatment to prevention and promotion – and between the health care system and other programs aimed at the broader determinants of health, including housing, food safety, income, education and literacy, environment, employment and physical security. It is precisely these points of intervention that hold out the most hope for equalizing conditions, opportunities and life chances of Canadians.

1. Preserving and Protecting Public Health Care

Canadians hold their public health system in very high regard. Some have argued that public health care is now a defining feature of Canadian identity. Specifically, Canadians firmly believe that access to health services must be provided on the basis of health need, and not on the ability to pay. No person should be turned away from service or shuffled down the queue because of their race, gender, age, religion, sexual orientation, political belief, economic or social condition. Equally as important, the risk of illness should not fall on an individual's or family's shoulders alone. Rather the risk should be collectively shared through the public funding and delivery of health services. No one should have to make the impossible choice between health care and other necessities of life.

These are the touchstones of Canadian health care – the parameters of health care reform. The success or failure of any reform initiative will turn – in our opinion – on the degree to which it reflects these underlying values. This is not a question of nostalgia; the weight of evidence and experience in Canada and elsewhere – documented ably in the Final Report of the National

Forum on Health – demonstrates the inherent value of a publicly funded and administered system of non-for-profit health services. Health care reform must work to reaffirm these values, now under threat from proponents of greater privatization.

These values are central to the mission of the CCSD and serve as our vantage point on the health care reform debate. We believe that health is a fundamental right of each citizen. Achieving health for all Canadians requires a system of public health that is organized on the basis of public administration, public insurance and the delivery of services on a not-for-profit basis. This is not to say that change is not necessary; change in the face of new realities – fiscal, demographic and technological – is critical to ensuring the integrity of the public system. To that end, the CCSD along with many other organizations endorse the need to preserve and protect Medicare by:

- Adopting a renewed vision for health care that identifies an integrated continuum of services and is focused on population health and the full range of factors that affect it. The principles of the Canada Health Act – universality of population coverage, access to required services, comprehensive supports, portability of benefits and public (non-profit) administration – are as relevant today as they were in 1984.

- Ensuring an integrated continuum of community-based and institutional services and supports. The first step in this process is to expand the public health care net – with the financial support of the federal government – to include home, community and long-term care programs and the provision of medically necessary drugs. At the same time, it is critical to preserve universal access to existing supports and services that have been targeted for de-listing or de-insuring.

- Strengthening the development and delivery of public health within the broader health services continuum, including allocating more appropriate levels of public resources from within global health budgets.

- Acting on primary care reform. Many provinces are already moving on primary care reform, with the support of the federal government. While there are many possible models, it is imperative that: funding follow the patient, not the service; that monetary incentives based on volume of service be removed from the system; that multidisciplinary teams of health care providers be encouraged; and that the rights of those with the highest health care needs be protected.

- Supporting needed health infrastructure, including: better information-sharing technologies; continued support for health research, including research into the broad determinants of population health; and effective public surveillance, evaluation and reporting to strengthen accountability and transparency.

- Facilitating public participation in the planning, delivery, monitoring and evaluation of the health care system. Engaging citizens in health promotion and reform is key to advancing health and well-being at the community level as well as enhancing public accountability.

- Providing stable funding. While many argue about the appropriate level and method of health care funding, no one disputes the fact that predictable funding is key to sustaining the system. To this end, the federal government must develop an appropriate annual escalator to apply to the CHST cash floor. The cash floor itself must be set at a level high enough to make the federal government a partner in shaping the national system. This might best be accomplished though major federal support for the expansion of community-based health services as part of a coherent public system, working with the provinces, municipalities and the non-profit sector. The federal government should also set aside funds (over a number of years) to meet urgent needs – for medical equipment, for example – as well as for expenses related to system change.

- Protecting our health system in international trade agreements. The federal government must actively resist efforts on the part of Canadian and multinational businesses to privatize our health care system through undemocratic bilateral and multilateral trade institutions.

Potential cost savings will be realized through system efficiencies gained by strengthening the public system. A number of studies, including the National Forum on Health, have argued that investment in prevention and health promotion will result in savings that can by applied to expanding public services. Prenatal nutrition programs, for example, have been shown to be very effective in reducing the incidence of low birth weight babies and the long-term costs associated with caring for these children. Similarly, the introduction of a pharmacare program may well cost money as we move from private to public financing and provision. But Joel Lexchin has argued that there will ultimately be savings down the road as the cost of drugs comes down – in his study, by an estimated 15% – and administrative efficiencies are achieved (Lexchin, 2001).

As we note above, the question of financing really hinges on determining the division of costs between public and private financing. Containing health care costs is really another issue. In one way or another, Canadians will end up paying for their health care – with their before-tax or after-tax dollars. We believe that public financing is the best way to ensure that health care services are accessible and affordable over the long term.

It may be that global health care costs will continue to rise; there is a long-term trend for all societies to spend more on public services, including health, as they become wealthier. However, this is not a matter of health "swallowing up" resources which could be better spent on other things, but rather a reflection of the fact that health is a public good which the vast majority of citizens wish to pay for, albeit efficiently. If the share of Canadian GDP going to public health care were to rise slowly over the coming decades in order to achieve further progress in the health of Canadians, including such areas as providing decent home care and community supports for an ageing population (since we are all ageing), it would not necessarily be a bad thing. Indeed, recent research suggests that generous redistributive transfers and accessible public services such as health care can have positive impacts on economic performance and levels of societal wealth (Jackson, 2000). "Societies that pursue more egalitarian policies often have faster rates of economic growth and higher standards of health" (Wilkinson and Marmot, 1998: 15).

In our view, the broad recommendations outlined above are critical to adapt our public health care system to serve the needs of Canadians in the 21st century. But as important as they are to preserving Medicare, we believe it is also imperative to reduce inequities in conditions that put many Canadians at a disadvantage for attaining and maintaining their optimal health.

2. Creating a More Equal and Inclusive Society

More equitable societies are healthier societies. The population health literature, reviewed above, provides compelling evidence of this. Individuals and families that participate in the social, economic and cultural life of their countries experience higher levels of well-being. This would involve tackling poverty and unemployment, in addition to other strategies to reduce the distance between citizens and foster recognition and respect among citizens that is fundamental to the realization of basic human rights.

While there is no simple recipe for greater equality, addressing poverty and income inequality are key to improving the health status of all Canadians and establishing the context of successful health care reform. While the responsibility for achieving greater equality is broadly shared among many social actors, governments have a unique command of the resources and the authority to affect progressive change. In conjunction with specific efforts to modernize Medicare, we believe that action is necessary to:

- close the employment gap;
- close the income gap; and,
- close the common goods gap.[1]

These strategies are not mutually exclusive. Just as social policy and economic policy work hand in hand – all too often to compound structural problems such as inequality – labour markets and social programs operate to support and sustain each other. The objective here is to reduce inequality through better regulation of the labour market, in conjunction with enhanced income benefits and social supports. As the experience of many European countries demonstrates, this formula works to raise all boats, including those of society's most vulnerable groups.

Closing the Employment Gap

The best income security program is a job. Over the last decade, this particular slogan has been linked to cutbacks in various income support programs. But if we take the phrase at its face value, higher levels of employment would most certainly reduce income inequality and reduce the need for government intervention across a range of fields, including health. However, it begs the question: what kind of job? And here, the real failure of the private market to distribute income equitably is revealed. In the real world, the labour market produces inequality – indeed, labour markets are generating greater inequality today, not less.

[1] We have borrowed the headings for this section from Armine Yalnizyan, *The Growing Gap* (Toronto: Centre for Social Justice, 1998), Part 6.

One of the key weaknesses of current social policy is that it refuses to enter the workplace, except in the most tentative of terms. Legislation on employment standards setting a minimum wage floor and regulating long and unsocial hours of work is in retreat almost everywhere. Less than one in five workers now has access to collective bargaining in the private sector. As employment shifts to more precarious forms of work and smaller workplaces, the sphere of regulation has receded, rather than expanded. Reform proposals which have been advanced for at least 20 years – such as proposals for equal pay and benefits for part-timers, limits on mandatory overtime – have gone nowhere.

Inclusion through paid work has profoundly different implications for individuals and families in Canada compared to those in countries such as Scandinavia and the Netherlands. In those countries, there are high wage floors, relatively much more equal earnings and household incomes, substantial protection from interruptions in income, high levels of employment security, lower and more stable working hours, and significant public and employer supports for workers and their families. To be sure, many employers in Canada do provide decent pay, benefits and employment security, but increasingly these benefits are reserved for a core of "privileged" workers. The large number of Canadians working in "marginal" sectors of the economy have little protection from the vicissitudes of the market. Progressive regulation of the market at both the federal and provincial levels is key to creating the conditions of equality, to closing the employment gap.

It is worth reiterating the call for:

- Increasing minimum wage.
- Pro-rating of benefits for part-time workers.
- Redistributing working time through limits on overtime, job sharing and enhanced leave provisions.
- Improving employment and pay equity legislation.
- Facilitating collective bargaining, notably in the private sector.
- Improving employment provisions for temporary or contract workers.
- Improving health and safety regulations.

Moving in this direction would narrow earnings differences and reduce stress and anxiety, as well as the physical health risks stemming from employment.

Closing the Income Gap

Pursuing full employment and improved working conditions is key to greater income equality. Yet even if higher levels of employment were achieved, there would still be individuals and groups within the working-age population who are highly vulnerable to poverty, and whose incomes either need to be met through social programs, or to be supplemented by social programs.

The high risk groups are those who have the greatest difficulty gaining access to decent jobs: Aboriginal people, persons with disabilities, single parents with children, and a more varied group with low or unrecognized skills which includes some recent immigrants, youth who have dropped out of school, and some older workers. These groups are vulnerable because of their partial exclusion from good jobs, combined with major gaps in our social programs. Those in marginal jobs often do not qualify for EI, and they tend to cycle back and forth between social assistance and

low-paying jobs. Canada risks having a growing underclass of Canadians who are redundant to the working of the economy.

Social assistance is a long-term trap for many. Single parents with children often find that a low-paying job does not provide sufficient resources to maintain a family, particularly in the absence of affordable, high-quality child care. Persons with disabilities face major barriers in terms of accessing employment, as do recent immigrants. Supports and services could make a major difference, but even if they are available, the problem of low pay in too many jobs remains a key cause of poverty, as noted above. The poor are either inside or outside the social assistance system, and few programs exist to supplement the incomes of the long-term working poor.

What we need above all in Canada are programs which recognize that some individuals and groups will be unable to gain an adequate income from the labour market alone, and they deserve support as they access job opportunities and make a productive contribution to society.

To be sure, recent and pending increases in the Canada Child Tax Benefit will make a major difference for working-poor families with children, complementing the major role that the federal government already plays in reducing poverty among the elderly. Yet there are no major federal or provincial programs to supplement the incomes of the disabled and the single working poor who are also vulnerable to deep poverty because of recurrent labour market problems and the inadequate and residual nature of provincial social assistance programs.

In our recent submission to the Prime Minister on income security reform, the CCSD recommended:

- Increasing social assistance incomes and services through increased federal transfers to the provinces, for supports such as child care and housing, combined with some shared development of national standards.

- Establishing a federal program, possibly modelled on CCTB, to provide income supplements to working-poor and modest-income households.

- Increasing existing federal tax credits (the CCTB and GST credits) and creating a new refundable tax credit for persons with disabilities.

- Extending the coverage of the EI system by revisiting restrictive eligibility requirements that have radically curtailed program coverage.

- Considering an Earned Income Tax Credit to supplement the incomes of working-age single Canadians who have employment but still fall below the poverty line.

These are only some of the issues that need to be looked at and avenues that should be explored. Creating a stronger income security system – particularly among working-age people and their families who are now the most vulnerable to poverty – would close the gap in health outcomes.

Closing the Common Goods Gap

The last strategy we would like to highlight is the critical need for enhanced public supports and services, especially for groups vulnerable to poor health and life outcomes. The availability of services touches the lives of Canadians in many ways. Housing, education, cultural and recreational opportunities, child care, public transit: all of these services enhance the lives of citizens, providing specific assistance in securing employment, in finding affordable housing, in learning to swim or to use a computer. Environmental protections, product standards, transportation safety regulations, basic municipal water and sewage infrastructure – the types of public supports that one doesn't necessarily see every day – all work to enhance and protect our collective quality of life and well-being.

The CCSD believes that public non-profit service provision directly reflects our collective commitment to each other. Public supports and services – including health care – create a "social commons." They create the context wherein individuals can develop their talents and capacities to the full and participate in the community in valued and recognized ways (Sen, 2000). They reduce the space – physical and otherwise – between citizens, thus fostering social cohesion. "Common goods 'decommodify' our world, enabling people to enjoy a decent life, not as a privilege or an accident of time and place, but as a human right in a world of plenty" (Yalnizyan, 1998: 105)

Public service provision through partnership with the voluntary sector also represents, as we have argued above, a better way to deliver human services and to ensure public accountability. Some goods are simply too important to leave to the vagaries of the market. As families who experienced the devastation of illness and disease before the advent of Medicare can attest, our health and well-being are much too important to leave to the market. As the people of Walkerton and other communities coping with contaminated water supplies can attest, environment regulations and protections are much too important to leave to the market. Strengthening the public network of non-profit services and supports – closing the common goods gap – is vital to securing the well-being of Canadians.

Conclusion

Public health care has been described as a public trust. And as such, we believe that the federal government has a central role to play in health care reform. Federal leadership and intergovernmental cooperation are necessary to address both short-term and long-term issues vital to the sustainability of our health care system. For the CCSD, a key component of this task is to take concrete action to reduce poverty and income inequality in Canada. To this end, the federal government has both the authority and the resources necessary to deal with the sources of inequality in Canada that contribute to poor health: growing polarization in the labour market; growing polarization of incomes; and inequitable access to critical public goods.

References

Applied Research Branch, Human Resources Development Canada. *Community Influences.* Research Workshop Report from the National Longitudinal Survey on Children and Youth conference "Investing in Children," 1998.

Anderson, G. et al. "Health Spending and Outcomes: Trends in OECD Countries, 1960-98," in *Health Affairs*, 19(3), 2000.

Anderson, G. and J. Poullier. "Health Spending, Access and Outcomes: Trends in Industrialized Countries," in *Health Affairs*, 18(3), 1999.

Armstrong, H.; P. Armstrong and D. Coburn, eds. *Unhealthy Times: The Political Economy of Health and Care in Canada.* Toronto: Oxford University Press, 2001.

Armstrong, P.; H. Armstrong and C. Fuller. *Health Care, Limited: The Privatization of Medicare.* Ottawa: Canadian Centre for Policy Alternatives, 2000.

Bartley, M.; D. Blane and S. Montgomery. "Health and the Life Course: Why Safety Nets Matter," in *British Medical Journal,* Vol. 314, 1997, pp. 1194-1196.

Browne, Paul Leduc. *Unsafe Practices: Restructuring and Privatization in Ontario Health Care.* Ottawa: Canadian Centre for Policy Alternatives, 2000.

Canada, The Standing Senate Committee on Social Affairs, Science and Technology. *The Health of Canadians: The Federal Role,* Interim Report. Vol. 1: *The Story So Far.* Ottawa: The Senate, 2001. (www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repintmar01-e.htm)

Canada, The Standing Senate Committee on Social Affairs, Science and Technology. *The Health of Canadians: The Federal Role,* Interim Report. Vol. 4: *Issues and Options.* Ottawa: The Senate, 2001. (www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repintsep01-e.htm)

Canadian Council on Social Development. *The Progress of Canada's Children 1999-2000.* Ottawa: CCSD, 2000.

Canadian Council on Social Development. *Letter to Prime Minister.* Ottawa, January 16, 2001. (www.ccsd.ca/pr/2001/letpm.html)

Canadian Healthcare Association. *CHA's Framework for a Sustainable Healthcare System in Canada: A Discussion Paper.* CHA Policy Brief No. 2. Ottawa: CHA Press, 2000. (www.canadian-healthcare.org)

Canadian Healthcare Association. *Funding Canada's Healthcare System.* CHA Policy Brief No. 1. Ottawa: CHA Press, 1999. (www.canadian-healthcare.org)

Canadian Healthcare Association. *A Responsive, Sustainable, Publicly Funded Health Care System in Canada: The Art of the Possible.* CHA Submission to the Romanow Commission, October 2001. (www.canadian-healthcare.org)

Canadian Institute for Health Information. *National Health Expenditure Trends, 1975-2000.* Ottawa: CIHI, 2000.

Canadian Institute for Health Information. *National Health Expenditure Trends, 1975-1999.* Ottawa: CIHI, 1999.

Canadian Institute for Health Information and Statistics Canada. *Health Care in Canada 2001.* Ottawa: CIHI, 2001.

Canadian Institute for Health Information and Statistics Canada. *Health Care in Canada 2000: A First Annual Report.* Ottawa: CIHI, 2000.

Canadian Union of Public Employees, BC Health Services Division. *Main Street Not Bay Street: Why We Need to Stop Corporations from Hijacking the Public Agenda on Health Information.* Vancouver: CUPE, 1998.

Deber, Raisa et al. "The Public-Private Mix in Health Care," in *Striking a Balance: Health Care Systems in Canada and Elsewhere*, 423–545. Vol. 4, *Canada Health Action: Building the Legacy.* Papers commissioned by the National Forum on Health. Sainte-Foy, Que.: Éditions MultiMondes, 1998.

Epp, J. *Achieving Health for All: A Framework for Health Promotion.* Ottawa: Health and Welfare Canada, 1986. (www.hc-sc.gc.ca/hppb/hpo/ahfa.htm)

Evans, R.; M. Barer and T. Marmor, eds. *Why are Some People Healthy and Others Not? The Determinants of Health of Populations.* New York: Aldine de Gruyter, 1994.

Federal/Provincial/Territorial Advisory Committee on Population Health. *Report on the Health of Canadians.* Ottawa: Health Canada, 1996. (www.hc-sc.gc.ca/iacb-dgiac/nhrdp/healthofcanadians/index-e.htm)

Federal/Provincial/Territorial Advisory Committee on Population Health. *Toward a Healthy Future: Second Report on the Health of Canadians.* Ottawa: Health Canada, 1999. (www.hc-sc.gc.ca/hppb/phdd/report/toward/eng/report.html)

Hamilton, N. and T. Bhatti. *Population Health Promotion: An Integrated Model of Population Health and Health Promotion.* Prepared for the Health Promotion Development Division, Health Canada, 1996. (www.hc-sc.gc.ca/hppb/phdd/php/php4.htm)

Hay, D. *Does Money Buy Health? An Empirical Investigation of the Relationship Between Income and Health.* Vancouver: Social Planning and Research Council of British Columbia, 1993.

Hertzman, C. "Population Health and Human Development," in D.P. Keating and C. Hertzman, eds. *Development Health and the Wealth of Nations*. New York: Guilford Press, 1999.

Jackson, A. *Why We Don't Have to Choose between Social Justice and Economic Growth: The Myth of the Equity-Efficiency Trade-off*. Ottawa: Canadian Council on Social Development, 2000. (www.ccsd.ca/pubs/2000/equity)

Jackson, A. "Globalization and Progressive Social Policy," Paper presented at the Tenth Biennial Conference on Canadian Social Welfare Policy, Calgary, 2001. (www.ccsd.ca/pubs/2001/ajglob.htm)

Jackson, A.; K. Scott and S. Schetagne. *A Good Year Tops Off A Lost Decade: A Preliminary Analysis of Income Trends in Canada to 1999*. Ottawa: Canadian Council on Social Development, 2001.

Kaplan, G. et al. "Inequality in Income and Mortality in the United States: Analysis of Mortality and Potential Pathways," in *British Medical Journal*, Vol. 312, 1996, pp. 999-1003.

Kawachi, I.; R. Wilkinson and B. Kennedy. "Introduction," in I. Kawachi, B. Kennedy and R. Wilkinson, eds., *The Society and Population Health Reader*. Volume I: *Income Inequality and Health*. New York: The New Press, 1999.

Kennedy, B. et al. "Income Distribution and Mortality: Cross Sectional Ecological Study of the Robin Hood Index in the United States," in *British Medical Journal*, Vol. 312, 1996, pp. 1004-1007.

Kent, Tom. *What Should Be Done About Medicare*. Ottawa: Caledon Institute, 2000.

Kreiger, N. "Theories for Social Epidemiology in the 21st Century: An Ecosocial Perspective," in *International Journal of Epidemiology*, Vol. 30, 2001, pp. 668-677.

Lantz, P. et al. "Socioeconomic Factors, Health Behaviours, and Mortality," in *Journal of the American Medical Association*, Vol. 279, 1998, pp. 1703-1708.

Legowski, B. and L. McKay. *Health beyond Health Care: Twenty-five Years of Federal Health Policy Development*. Ottawa: CPRN, October 2000. (www.cprn.ca)

Lexchin, J. *A National Pharmacare Plan: Combining Efficiency and Equity*. Ottawa: Canadian Centre for Policy Alternatives, 2001.

Lynch, J. "Income Inequality and Health: Expanding the Debate," in *Social Science and Medicine*, Vol. 51, 2000, pp. 1001-1005.

Marmot, M. *Explaining Socioeconomic Differences in Sickness Absence: The Whitehall II Study*. Toronto: Canadian Institute for Advanced Research, 1993.

Marmot, M. and F. Mustard. "Coronary Heart Disease from a Population Perspective," in *Why are Some People Healthy and Others Not? the Determinants of Health of Populations*, R. Evans, M. Barer and T. Marmor, eds. New York: Aldine de Gruyter, 1994.

Marmot, M. and R. Wilkinson, eds. *Social Determinants of Health*. Oxford: Oxford University Press, 1999.

Marsh, L.; A. Grant and C. Blackler. *Health and Unemployment: Some Studies of their Relationships*. Montreal: McGill Social Research Series No. 7, 1938.

Montague, P. "Economic Inequality and Health," in *Rachel's Environment and Health Weekly*, No. 497, 1996. (www.monitor.net/rachel/r497.html)

National Forum on Health. *Canada Health Action: Building on the Legacy*. Vol. 1: *The Final Report of the National Forum on Health.*. Ottawa: National Forum on Health, 1997. (www.nfh.hc-sc.gc.ca/publicat/finvol1/1trans.htm)

National Forum on Health. *Canada Health Action: Building on the Legacy*. Vol. 2: *Synthesis Reports and Issues Papers*. Ottawa: National Forum on Health, 1997. (www.nfh.hc-sc.gc.ca/publicat/finvol2/vol2.htm)

National Forum on Health. *The Public and Private Financing of Canada's Health System*. Ottawa: National Forum on Health, 1995. (www.nfh.hc-sc.gc.ca/publicat/public/idxpuble.htm)

Osberg, L. "The Equity-Efficiency Trade-off in Retrospect," in *Canadian Business Economics*, 3(3), 1995.

Quebec. Ministère de la Santé et des Services sociaux (MSSS). Commission d'étude sur les services de santé et les services sociaux (Clair Commission). *Les solutions émergentes : Rapport et recommendations*. Québec: MSSS, 2001. (www.cessss.gouv.gc.ca)

Rachlis, M.; R. Evans; P. Lewis and M. Barer. *Revitalizing Medicare: Shared Problems, Public Solutions*. Vancouver: Tommy Douglas Research Institute, January 2001. (www.tommydouglas.ca/papers/medicare.pdf)

Raphael, D. "Health Effects on Economic Inequality: Overview and Purpose," in *Canadian Review of Social Policy*, No. 44, 1999.

Raphael, D. "From Increasing Poverty to Societal Disintegration: How Economic Inequality Affects the Health of Individuals and Communities," in *Unhealthy Times: The Political Economy of Health and Care in Canada*, H. Armstrong, P. Armstrong and D. Coburn, eds. Toronto: Oxford University Press, 2001a.

Raphael, D. *Inequality is Bad for Our Hearts: Why Low Income and Social Exclusion are Major Causes of Heart Disease in Canada*. Toronto: Toronto Heart Health Network, 2001b. (www.yorku.ca/wellness/heart.pdf)

Reid, D. et al. "Cardiorespiratory Disease and Diabetes Among Middle-Aged Male Civil Servants," in *Lancet,* Vol. I, 1971, pp. 469-73.

Rose-Ackerman, S. "Altruism, Non-profits and Economic Theory," in *The Journal of Economic Literature*, 34(2), 1996.

Ross, D.; K. Scott and M. Kelly. *Child Poverty: What Are the Consequences?* Ottawa: Canadian Council on Social Development, 1996.

Ross, D.; K. Scott and P. Smith. *The Canadian Fact Book on Poverty 2000.* Ottawa: Canadian Council on Social Development, 2000.

Ross, N. et al. "Relation Between Income Inequality and Mortality in Canada and the United States," in *British Medical Journal*, Vol. 320, 2000, pp. 898-902.

Saskatchewan Commission on Medicare (Fyke Commission). *Caring for Medicare: Sustaining a Quality System.* Regina, SK: Government of Saskatchewan, 2001. (http:// www.medicare-commission.com)

Sen, A. *Development as Freedom.* New York: Anchor Books, 2000.

Shaw, M. et al. *The Widening Gap: Health Inequalities and Policy in Britain.* Bristol, UK: The Polity Press, 1999.

Taft, K. and G. Steward. *Clear Answers: The Economics and Politics of For-Profit Medicine.* Edmonton: Duval House Publishing / The University of Alberta Press / Parkland Institute, 2000.

Taylor, E.; R. Repetti and T. Seeman. "What is an Unhealthy Environment and How Does it Get Under the Skin," in *Annual Review of Psychology*, Vol. 48, 1997, pp. 411-447.

Toronto Public Health Department. *A Profile of Public Health in 2001.* 2001.

Tuohy, Carolyn Hughes, PhD; Colleen M. Flood, SJD, and Mark Stabile, PhD. *How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations.* Toronto: University of Toronto, 2000.

Wilkins, R. et al. "Changes in Mortality by Income in Urban Canada from 1971 to 1986," in *Health Reports*, 1(2), 1989.

Wilkins, R. "Mortality by Neighbourhood Income in Urban Canada, 1986-1991," Paper presented at the Conference of the Canadian Society for Epidemiology and Biostatistics, St. John's, Newfoundland, August 1995.

Wilkins, R. "Health Status of Children," in *Health Reports*, 11(3), 1999.

Wilkinson, R. *Unhealthy Societies: The Afflictions of Inequality.* New York: Routledge, 1996.

Wilkinson, R. and M. Marmot. *Social Determinants of Health: The Solid Facts*. Copenhagen: World Health Organization, 1998. (www.who.dk/healthy-cities)

Wolfson, M. "On the Health of Canadians across the 49th Parallel," Paper presented at Queen's University Institute for Social Policy, 2000.

Wood, E. et al. "Social Inequalities in Male Mortality Amenable to Medical Intervention in British Columbia," in *Social Science and Medicine*, Vol. 48, 1999, pp. 1751-1758.

Woolley, F. "The Strengths and Limits of the Voluntary Sector," in *ISUMA*, 2(2), 2001.

Yalnizyan, A. *The Growing Gap: A Report on Growing Inequality between the Rich and Poor in Canada*. Toronto: Centre for Social Justice, 1998.